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AUTHOR Berman, Dene S.; Davis-Berman, Jennifer
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ABSTRACT

This paper presents a model for determining appropriate provider qualifications in a variety of adventure settings, in which adventure-based activities are used, but particularly the qualifications and training needs of adventure therapists. The model is based on the premise that the skill and educational needs of providers increase with the physical and emotional risk associated with adventure activities, with the increased needs of participants, and with program goals. Adventure-based activities are utilized with a variety of populations ranging from emotionally healthy to emotionally unstable. Program goals can reflect recreation, education/enrichment, adjunctive, or therapeutic goals, which require different levels of skills in providers. This model suggests that many people will have the basic educational and technical background needed to provide services to low-risk populations, who are engaged in recreational or educational activities with little or no risk. Few providers will have the requisite education and skill levels to work with high-risk populations, to lead potentially dangerous activities, or to pursue the goal of providing therapy. Strategies for ensuring that providers have all the skills needed for a given situation include partnerships between mental health professionals and experiential educators, cross-training for the two groups, and hybrid training that aims at synthesis. Figures illustrating the model are included. (LP)

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TRAINING ADVENTURE THERAPISTS: A MENTAL HEALTH PERSPECTIVE

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Dene S. Berman, Ph.D.

Lifespan Counseling Associates

Jennifer Davis-Berman, Ph.D.

University of Dayton

and

Lifespan Counseling Associates

Mailing Address: 1698 Forestdale Ave

Dayton, OH 45432

(513) 426-2079, (513) 426-0211 fax

Running Title: Adventure Therapists

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TRAINING ADVENTURE THERAPISTS: A MENTAL HEALTH PERSPECTIVE

Adventure therapy is an emerging field. As such, there are extant issues concerning the qualifications and training of adventure therapists. We will be addressing training issues in the adventure education field by presenting a model that can be utilized to conceptualize the needs of professionals practicing in this field. We do so as mental health professionals who have entered the field from a direction that is probably very different than that of most adventure therapists. Jennifer is a social worker and Associate Professor of Sociology at the University of Dayton. Dene Is a psychologist and Clinical Professor of Professional Psychology at Wright State University. Together, we have a private counseling practice, a component of which is the Wilderness Therapy Program, an adventure-based, intensive counseling program for troubled adolescents.

Two major events led us to begin thinking and writing about training issues in adventure therapy. The first was after we published our first article on wilderness therapy (Berman & Anton, 1988). Shortly after it was published, we received a call from a man from a western state who told us that he was offering a wilderness program as an alternative to hospitalization for troubled youth. He wanted to use our article as an insert to his program brochure in order to help convince parents that wilderness therapy is credible treatment. When we asked

him about his credentials, he told us that he is an ex-marine drill sergeant who learned in the military how to work with young men. He then proceeded to tell us about how he took adolescents (some of whom had to be physically restrained and taken forcibly in order to go on his trips), and taught them survival skills. Needless to say, we had serious reservations about this so-called "therapy."

The second event that led us to think about training issues was when we were invited by the Council on Accreditation of Services for Families and Children to participate on a national task force to write standards for residential wilderness therapy programs. When we went to a task force meeting in early 1992, we were able to talk about the kind of credentials wilderness therapists need from the perspective of representatives from some of the largest residential programs in the country. The general consensus was that wilderness counselors do not have to have credentials, except that they have to be at least 21 years of age, in good health, and with demonstrated technical skills (COA, 1993). We were a dissenting voice when we advocated for more rigorous standards for staff credentials. Essentially, our position was that programs dealing with troubled youth, especially those advertising as an alternative to psychiatric hospitalization, need to be held to a higher standard. Thes credentials should be no different than those of professionals providing mental health services in more traditional

settings. Since then, we have written extensively about our views (Berman & Davis-Berman, 1991, 1992, 1993; Davis-Berman and Berman, 1993, 1994).

The evolution of our thinking has led us to now suggest that the issue of staff credentials is complex and must be considered within the context of the specific program and its participants. There are some situations in which staff should be licensed mental health professionals, but many others, in which these credentials are not necessary. Similarly, there are situations in which professionals should have highly technical outdoor recreation skills.

While we might all agree, in principle, that psychiatric patients who are recipients of wilderness programming as a form of psychotherapy should be treated by individuals with high levels of skill and training, there would be less consensus about standards of professional competence when other scenarios are considered. For example, our expectations about professional credentials might be very different if we considered playing "couple's tag" with a group of third graders in order to sensitize them about the need for people to work together as part of a team. It is our goal to present a model for determining provider qualifications in a variety of different settings in which adventure-based activities are used to enhance participants' growth and development.

Let us begin by considering the skill and educational needs of providers by looking at them as a function of different conditions. Some activities that might be used offer little or no risk to participants, while others present high levels of risk. This dimension of "riskiness" can be represented as a continuum from low risk to high risk. At the low end might be games in which there is no bodily contact and little self-disclosure where the participants are having fun. The "name game" could be representative of low risk activities.

On the other hand, some adventure-based activities contain high elements of risk in that they are potentially dangerous physically or emotionally. A physically potentially dangerous activity, for example, might involve white-water rafting. Our model suggests that as the riskiness of the activity increases, the leaders need increasing skills and professional education. This notion of "riskiness" is depicted in Figure 1.

Insert Figure 1 about here

Adventure-based activities are utilized with a variety of populations. Some of those populations are emotionally very healthy, like the individuals who participate in leadership programs for highly achieving students. At the other extreme are individuals who are very

unstable emotionally, such as might be found in a psychiatric hospital wilderness program for patients. Again, we suggest that this dimension be looked at as a continuum, in this case of the needs of the population with low needs (i.e., stability) at one end and high needs (instability) at the other. As the needs of the population increase, the skill and educational needs of the leaders should also increase, as may be seen in Figure 2.

Insert Figure 2 about here

Another dimension that deserves attention relates to the goals of the program. We have utilized the categories generated by Gillis et al. (1991) for programs that focus primarily on recreation, education/enrichment, adjunctive, or therapeutic goals. Recreational programs might be those that offer fun and challenge; enrichment and educational programs aim to help increase people's awareness or learn new skills; adjunctive programs may be seen as augmenting other services, as a ropes course can be used in a substance abuse program; and adventure is used as therapy when the goals are to alleviate psychiatric problems. This continuum of program goals is represented in Figure 3 and suggests increasing needs of providers as being linked to increases in program goals.

Insert Figure 3 about here

These dimensions can be put together in such a way that the needs of the providers can be seen as a function of the activity, the population and the program goals. These dimensions can be visualized as the three ascending sides of a pyramid, with provider needs increasing in a corresponding fashion, as may be seen in Figure 4.

Insert Figure 4 about here

A further aspect of this pyramid that can be seen is that the base is much larger that the peak. This can be taken to suggest that there will be many more people who have the basic educational and technical background needed to provide services to low risk populations, who are engaged in activities with little potential for harm, in programs whose goals are recreational or educational. There will be few providers with the requisite education and skill levels to work with high risk populations, who are engaged in potentially dangerous activities, with the goal of providing therapy.

Let us again consider the drill sergeant who puts troubled adolescents in wilderness settings (in which they have to use survival

skills) as an alternative to traditional psychiatric hospitalization. It should be clear, from our model, that "Sarge" is in over his head, and his clients are unlikely to reap the benefits that are proffered. Thus far, it may be easier to determine when one's leadership needs are inadequate that to determine what they should be. That is, the model may be more proscriptive than prescriptive.

Determining provider qualifications is a difficult task, at best. Turf battles are likely to ensue with lines drawn in the sand in an attempt to dictate who should do what, when, and where. We believe that there is a more rational approach to making these determinations, and that is by considering the aforementioned three dimensions of risk, population and goals and then considering provider qualifications for each of these permutations. This approach is outlined in Table 1.

Insert Table 1 about here

Filling in the empty spaces in the column labeled "provider qualifications" is beyond the scope of this presentation. It is our hope, however, that the model we have proposed will serve as a heuristic in making those determinations.

The goals may eventually be for each provider to have all the skills needed for a given situation. In the interim, there may be

alternate ways of reaching this goal. One possibility, now achievable, is to seek partnerships between mental health professionals and experiential educators. A second option is to pursue cross-training in which experiential educators would obtain training in counseling and counselors would gain experiential education training. These possibilities may not be as desirable as hybrid training. Different than cross-training in that synthesis is the goal, hybrid training opportunities are on the horizon. Two types of hybrid training programs currently exist. A number of Recreation Therapy programs are trying to offer training in mental health and outdoor education. From the mental health direction, there is a new program at Georgia College offering a master's degree in psychology with an emphasis in adventure therapy.

This presentation has been aimed at providing a framework for determining the needs of adventure therapists. We join you in the collaborative effort of further refining this model and the training opportunities that will meet the needs of an emerging field.

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DIFFERING CONDITIONS WILL DICTATE DIFFERENT PROVIDER QUALIFICATIONS

RISK	POPULATION	GOALS	PROVIDER QUALIFICATIONS
-	-	REC	
+	-	REC	
-	+	REC	
+	+	REC	
-	-	ED	
+	-	ED	
-	+	ED	
+	+	ED	
-	-	ADJUNCTIVE	
+	-	ADJUNCTIVE	
-	+	ADJUNCTIVE	
+	+	ADJUNCTIVE	
-	-	THERAPY	
+	-	THERAPY	
-	+	THERAPY	
+	+	THERAPY	

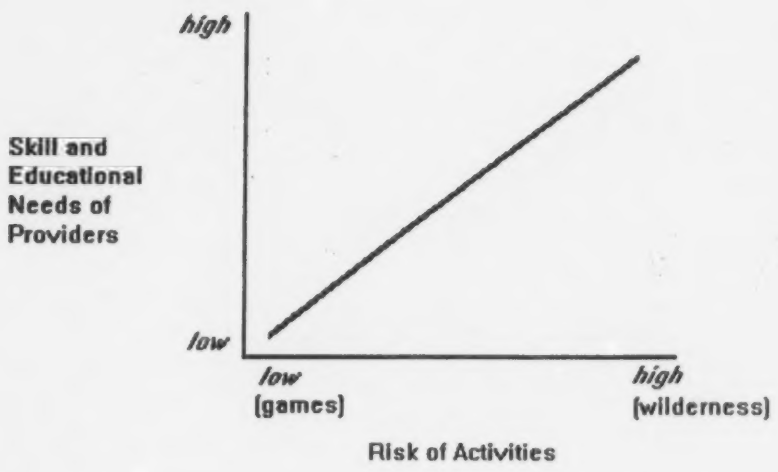

Figure 1. The skill level and educational needs of providers increases with the riskiness of activities.

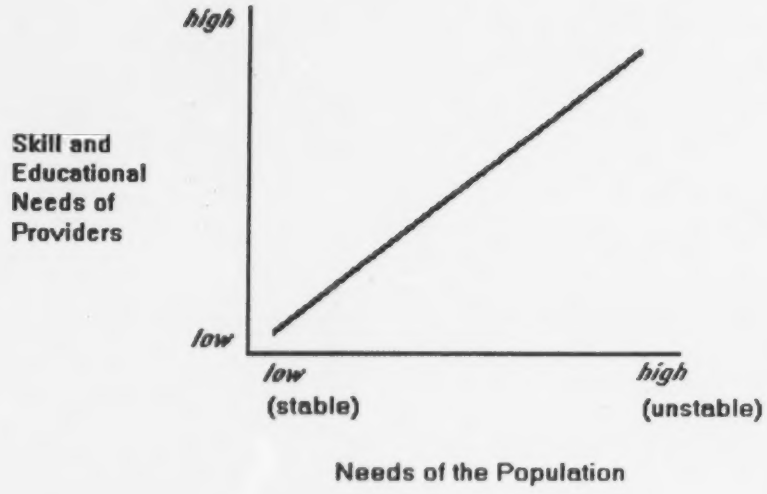

Figure 2. The skill level and educational needs of providers increases with the needs of the population.

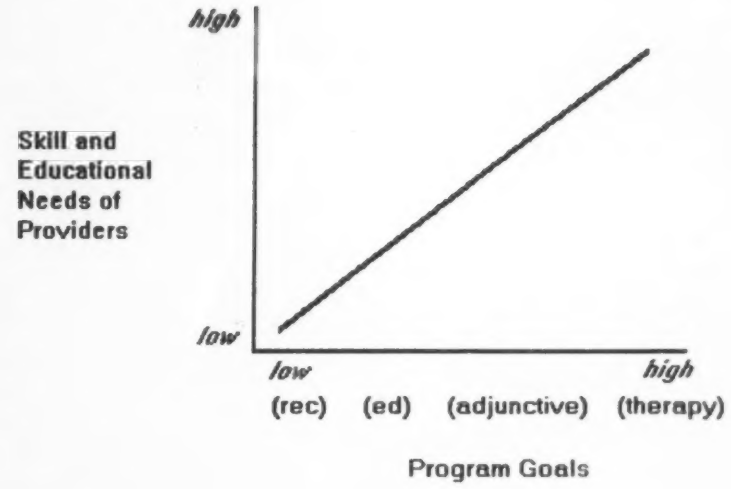

Figure 3. The skill level and educational needs of providers increases with the program goals.

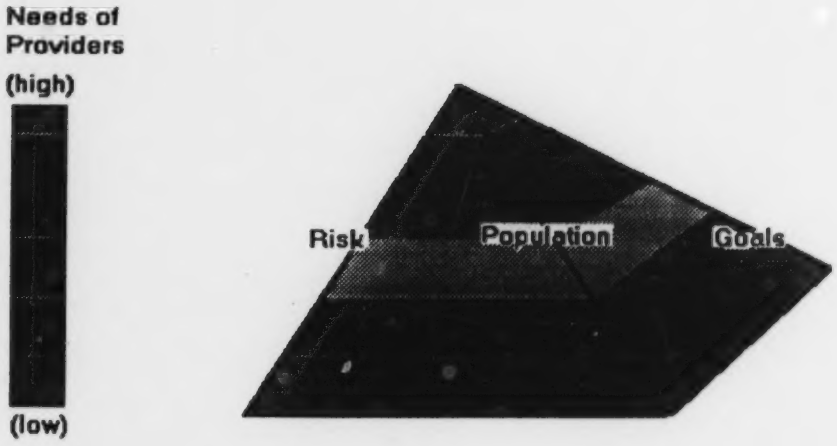

Figure 4. Conceptual model for determining the skill level and educational needs of providers.